

# EXHIBIT 13

**JONATHAN M. VAPNEK, M.D.**

**UROLOGY**

**229 EAST 79<sup>TH</sup> STREET . NEW YORK, NEW YORK 10075 . TELEPHONE (212) 717-9500**

December 15, 2021

Emery Celli Brinckerhoff Abady Ward & Maazel LLP  
600 Fifth Avenue, 10<sup>th</sup> Floor  
New York, NY 10020  
Attn: Katherine Rosenfeld, Esq.

Re: Matthew Raymond v. Troy Mitchell, et al. (W.D.N.Y.)

Dear Ms. Rosenfeld:

At the request of your office, I have reviewed and evaluated the medical and surgical care provided to Matthew Raymond, in order to provide my professional opinions as to the cause and consequences of any injuries sustained by Mr. Raymond. In performing my evaluation, I have reviewed the applicable medical and surgical records and documents, including the following:

- Plaintiff's expert neurology report – Sherry A. Leitch, M.D. – 7/23/21
- Defense expert urology report – John R. Valvo, M.D. – 10/18/21
- Defense expert neurology report – Robert Knapp, M.D. – 10/7/21
- Outpatient Records of Upstate University Hospital – 1/19/17 – 7/22/18
- Inpatient Records of Upstate University Hospital – 4/26/17 – 4/28/17 admission
- Inpatient Records of Upstate University Hospital – 6/6/17 – 6/9/17 admission
- Inpatient Records of Upstate University Hospital – 9/5/17 – 9/10/17 admission
- Inpatient Records of Upstate University Hospital – 7/30/17 – 8/2/17 admission
- Inpatient Records of Upstate University Hospital – 7/10/18 – 7/11/18 admission
- Records of Western New York Urology Associates – 3/10/20 – 11/10/21
- Emergency Department Records of Erie County Medical Center – 2/9/20 – 2/11/20
- Emergency Department Records of Erie County Medical Center – 2/27/20
- Emergency Department Records of Kenmore Mercy Hospital – 2/28/20 – 3/2/20
- Emergency Department Records of Kenmore Mercy Hospital – 4/1/20 – 4/2/20
- Emergency Department Records of Kenmore Mercy Hospital – 6/21/20
- Inpatient Records of Buffalo General Medical Center – 11/17/20 – 11/24/20
- Inpatient Records of Buffalo General Medical Center – 11/29/20 – 12/4/20
- Inpatient Records of Buffalo General Medical Center – 7/6/21 – 7/10/21
- Inpatient Records of Buffalo General Medical Center – 7/19/21 – 7/28/21
- Inpatient Records of Buffalo General Medical Center – 8/16/21 – 8/20/21
- Ambulatory Surgery Records of Buffalo General Medical Center – 11/10/21

All of my opinions in this report are issued based on my training and education and are stated to a reasonable degree of medical certainty.

Matthew Raymond, then 28 years old, was assaulted by a New York State Corrections officer on September 14, 2016, sustaining blows to his neck, head, face, chest and genital region using closed fist and a baton.

Shortly after that incident, he developed difficulty urinating but didn't undergo urological evaluation until he was taken to the Emergency Department at Upstate University Hospital on January 19, 2017 where he complained of dysuria and increasing difficulty urinating. He was diagnosed with urinary retention after a bladder scan demonstrated over 600 cc of urine in his distended bladder. A foley catheter was placed with immediate relief of pain as well as the marked tachycardia that accompanied his bladder distension.

Five days later, he was seen by Urologist Timothy Byler, M.D., at Upstate University Hospital, who documented Mr. Raymond's increasing difficulty voiding following the September 14, 2016 incident, culminating in the E.D. visit five days prior. Because of a history of gross hematuria in addition to the painful urination, Dr. Byler felt that Mr. Raymond's difficulty urinating was likely secondary to a traumatic urethral stricture. He referred him to Interventional Radiology where a suprapubic catheter was placed percutaneously on February 10, 2017.

At a follow-up appointment in the Urology clinic a month later, it was noted that Mr. Raymond had been unable to urinate after clamping the suprapubic catheter several times over the prior month. On March 7, 2017, he underwent cystoscopy and a voiding cystourethrogram, both of which were completely normal, thereby ruling out urethral stricture as the cause of his urinary retention.

On April 26, 2017, Mr. Raymond presented to the Emergency Department at Upstate University Hospital for the first of many subsequent visits, with complaints of worsening lower abdominal pain with radiation to the flanks associated with a mildly elevated white blood cell count plus tachycardia and hypertension. He was admitted to the hospital, treated with intravenous antibiotics for presumed urinary tract infection, and had the suprapubic catheter exchanged by the Urology service. He was discharged two days later. On this admission and multiple subsequent admissions, imaging studies were done, including sonography and/or CT scanning, none of which showed characteristic findings of pyelonephritis.

There were three subsequent hospital admissions in June, July and September of 2017. During that third admission, he was seen by Urologist Dmitriy Nikolavsky, M.D., who subsequently saw him following discharge in the Urology clinic on October 24, 2017. On that date, Mr. Raymond once again failed a trial of void with a bladder volume of 320 cc. On November 21, he underwent a urodynamic study which demonstrated a first sensation of fullness of 101 cc, a bladder capacity of 216 cc but no evidence of a bladder contraction. After unsuccessfully attempting to void by straining, the study was terminated, and the suprapubic tube was unclamped.

Because of Mr. Raymond's persistent urinary retention along with continued difficulties with the suprapubic catheter leading to multiple emergency department visits and hospital admissions, the urologists at Upstate University Hospital discussed alternate bladder management strategies with him. Given his persistent urogenital pain, Mr. Raymond could not consider intermittent self-catheterization through his native urethra. However, he expressed interest in undergoing augmentation cystoplasty with creation of a continent catheterizable channel to the skin to allow periodic emptying of the augmented bladder by catheterization through the abdominal stoma.



Mr. Raymond's bladder was managed with an indwelling suprapubic catheter from early 2017 through early 2020, when he was released from prison. He was first seen by the physicians at Western New York Urology Associates on March 10, 2020. He had multiple subsequent outpatient visits leading up to November 17, 2020, when he was taken to the operating room by Urologist Teresa Danforth, M.D., who performed augmentation cystoplasty with creation of a catheterizable channel using ileum. His initial postoperative course was unremarkable, and he was discharged on postoperative day #7. He was readmitted 5 days later because of an abdominal abscess that required drainage and parenteral antibiotics. He was discharged on December 4.

Unfortunately, he developed an incisional hernia that required additional surgery to repair it on July 6, 2021. Because the hernia was too large to be closed primarily, bridging mesh was placed. After a somewhat complex hospital course, he left the hospital AMA on postoperative day #4, only to return to the E.D. the following day. His wound dressing was changed, and he was discharged home. He was readmitted on July 19 with an infected abdominal wound and was taken back to the operating room three days later for removal and replacement of the infected mesh. He was discharged on July 28, 2021. There was one additional hospital admission on August 16 because of another wound infection requiring intraabdominal washout in the operating room on August 19 and then discharged home on August 20, 2021. On November 10, 2021, he underwent split thickness skin grafting to achieve closure of the chronic abdominal wound on an ambulatory basis.

In summary, Mr. Raymond was 28 years old, with no prior urological history at the time of the assault of September 14, 2016. After that incident, he developed increasing difficulty urinating associated with pelvic pain and had a foley catheter placed in January of 2017 followed by a suprapubic catheter the following month. After failing multiple voiding trials, urodynamic studies were performed and confirmed a small capacity neurogenic bladder that did not contract. At the age of 34, he underwent major reconstructive surgery of the bladder and currently manages his bladder by self-catheterization through the catheterizable channel.

As a practicing neuro-urologist, I see patients with neurogenic bladders from obvious causes like spinal cord injury, multiple sclerosis and Parkinson's disease, but I also frequently see patients with voiding dysfunction without an obvious neurologic etiology. Mr. Raymond's urodynamic study in November of 2017 was abnormal – his bladder was unable to contract – otherwise known as detrusor areflexia or detrusor acontractility. His urinary function was normal prior to the September 2016 assault and became markedly abnormal afterwards. While it is helpful to have abnormal imaging or an abnormal neurological examination to bolster the diagnosis of neurogenic bladder, there is no requirement for such evidence.

It is abundantly clear that the assault of September 14, 2016 was the precipitating cause for Mr. Raymond's voiding dysfunction, given the absence of any suitable alternative explanation. This severe voiding dysfunction led to the necessity for suprapubic catheter placement, with all of its attendant complications, followed by major reconstructive surgery of the bladder, with its own set of attendant complications, including multiple emergency department visits, hospitalizations and surgical procedures. The fact that each and every one of those hospital admissions prior to bladder reconstruction was associated with tachycardia and hypertension is consistent with the autonomic nervous system dysfunction that often accompanies the diagnosis of neurogenic bladder.

Defense urology expert John Valvo, M.D., argues that Mr. Raymond's bladder dysfunction is inconsistent with the type of neurogenic bladder seen following a traumatic brain injury. The classic textbook description of neurogenic bladder dysfunction secondary to a brain injury or brain lesion such as stroke or multiple sclerosis is detrusor overactivity with urinary urgency and urge incontinence. However, given the complexity of brain

function, especially in patients with a prior history of traumatic brain injury, brain lesions can lead to bladder and sphincter dysfunction that led to urinary retention rather than urge incontinence. For example, the coordination of bladder and sphincter function occurs at the level of the pons, and a subtle lesion at that level could lead to urinary retention rather than detrusor overactivity with urge incontinence.

Similarly, Dr. Valvo argues that the trauma to Mr. Raymond's brain was insufficient to lead to such a dramatic change in bladder function. While imaging studies of his brain did not reveal any obvious evidence of trauma such as a hematoma, it is clear that he developed multiple issues consistent with TBI such as headaches, difficulty with concentration and marked cognitive dysfunction. The development of pelvic pain and the inability to volitionally relax the external urethral sphincter to allow voiding to occur is certainly consistent with a cognitive issue following TBI. While the urodynamic study of November, 2017 demonstrated a small capacity bladder without demonstrable detrusor overactivity, a non-relaxing external sphincter due to CNS dysfunction can lead to detrusor acontractility and urinary retention.

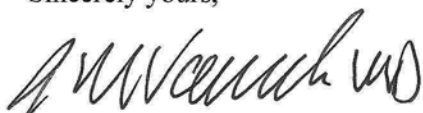
Finally, Dr. Valvo feels that neurogenic bladder dysfunction should have developed much more acutely than it did in Mr. Raymond's case. Once again, while his argument definitely applies to the classic description in the textbooks when applied to an obvious brain lesion such as stroke or tumor or brain bleed, a more subtle injury could certainly become clinically apparent over a longer period of time. In Mr. Raymond's case, given the fact that he was incarcerated, it is even more likely that the early signs of voiding dysfunction were missed, leading to his presentation to the emergency room in urinary retention four months following the injury.

Finally, while Dr. Valvo correctly states that Mr. Raymond's presentation and clinical findings are not consistent with the classic descriptions of neurogenic bladder dysfunction, he offers no alternative explanation for Mr. Raymond's severe voiding dysfunction that clearly began after the September 14, 2016 assault. Whatever the mechanism, it was that assault that led to Mr. Raymond's inability to urinate and the consequent necessity for suprapubic catheter placement in 2017 followed by major reconstructive surgery in 2020.

Mr. Raymond currently manages his augmented neurogenic bladder via intermittent self-catheterization through a catheterizable abdominal channel and can no longer void on his own. His damages are permanent and causally related to the assault of September 14, 2016. He will need close urologic monitoring for life because of the substantial complication rate associated with the major reconstructive surgery he underwent in November of 2020.

All of my opinions are stated to a reasonable degree of medical certainty and are based on my review of the medical records, as well as my knowledge, education and training and experience as a Board Certified urologist for over 25 years. I reserve the opportunity to amend this report as may be necessary to incorporate such additional information as well as any additional or amended professional opinions which may result from the review.

Sincerely yours,



Jonathan M. Vapnek, M.D.  
Clinical Associate Professor of Urology  
The Icahn School of Medicine at Mt. Sinai